907 KAR 3:030E
Material Incorporated by Reference

IMPACTPlus Manual
(September 1998 edition)

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IMPACT PLUS MANUAL

KENTUCKY MEDICAID PROGRAM POLICY AND PROCEDURES

907 KAR 3:030
Coverage and Payments for Impact Plus Services

September 1998

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

IMPACT PLUS APPENDIX

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Impact Plus Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage and policy. Precise adherence to policy shall **be** imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall **be** bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

II. KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally. some of these policies are as follows:

All participating providers shall 'agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care,

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

The provider's adherence *to* the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore. claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be' responsible for a portion of the medical expenses they have incurred.

B. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d)(5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. ONLY twelve (12) months shall elapse between EACH RECEIPT of the aged claim by the program.

C. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

D. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-in.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager and pharmacy shall appear on the face of the card.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. General Information

Effective January 1, 1998, the Department for Medicaid Services (DMS) will provide coverage and payment for Impact Plus Services by agreement with the state Title V agency, the Department for Public Health. Impact Plus covers targeted case management and rehabilitative services for children under age 21 with complex behavioral health treatment needs.

B. Provider Qualifications

(1) Provider participation is limited to the Department for Community Based Services (DCBS) and the Department for Mental Health and Mental Retardation Services (DMHMRS) and the Department for Public Health (DPH) as the Title V state agency in accordance with the requirements set forth in 907 KAR 3:030.

The following participation forms are required to be completed by, each provider of services:

(1) Provider Agreement (MAP-343)
(2) Provider Disclosure Form (MAP-34%)
(3) Provider Information Sheet (MAP-344)

After receipt of these completed farms, the DMS shall assign a provider number to be used for identification and billing purposes.

(2) Subcontractor qualifications shall be any of the following:

(a) Independent Clinical Practitioners:

(1) Psychiatrists or other licensed medical doctors

(2) Licensed Psychologist in accordance with KRS 319.050

(3) Certified Psychologist with Autonomous Functioning

(4) Licensed Clinical Social Worker (LCSW)

(5) Master's level Social Worker employed by the DCBS and providing service in accordance with KRS 335.01 0(4)

(6) Advanced Registered Nurse Practitioner (ARNP)

(7) Certified Marriage and Family Therapist

(8) Certified Professional Counselor

(9) Certified Professional Art Therapist

(10) Certified Alcohol and Drug Counselor (Limited to Substance Abuse Services)

(b) Group Providers

Group providers may be any of the following:

(1) Licensed hospital in accordance with 902 KAR 20:009, 20:016E and 902 KAR 20:170, 20:180 and 20:012

(2) Licensed community mental health center in accordance with 902 KAR 20:091.

(3) Child placing or caring facility in accordance with 905 KAR 1:300 and 905 KAR 1:310

(4) Drug Abuse Treatment and Education (DATE) Centers in Accordance with 908 KAR 1:010-260

(5) Non-Medical Alcohol Treatment and Education (NATE) Centers in Accordance with 908 KAR 1:010-260

(6) Organizations accredited by The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)

(7) Organizations accredited by the council on Accreditation of **Services for Families and Children (COA),**

All subcontractors shall, as a part of the application process to become a sub-provider, provide either verification of a state police records check or signed releases to enable DMHMRS or DCBS to complete a state police records check. Each sub-contractor, if unable to provide required verification, both group and individual, shall include a check, payable to the Kentucky State Treasurer, for the cost of obtaining the records check.

(3) Subproviders who are employed by or under contract to an Independent Clinical Practitioner or a group provider

(a) Practitioners with Clinical Supervision

(1) Psychological Associate or Certified Psychologist under the supervision of a Licensed Psychologist in accordance with KRS 319.064 or KRS 319.056

(2) Certified Social Worker under the supervision of a Licensed Clinical Social Worker (LCSW) in accordance with KRS 335.080

(b) Therapeutic Support Staff

(1) Therapeutic Child Support Professional under the supervision of an Independent Clinical Practitioner or Practitioner with Clinical Supervision

Therapeutic Child Support Professional shall:

(aa) have a Bachelor's degree or be a Registered Nurse; and

(bb) have three (3) years of experience working with children with behavioral health needs: and

(cc) have 60 class hours of training in children's behavioral health (three (3) college level credits in courses related to child development or services to children in an accredited academic institution *is* equivalent to 30 class hours of training); and

(dd) complete required training within six months of employment or by January 1,1999 if employed *at* the initiation of 907 KAR 3:030.

Therapeutic Child Support Professionals assist in the development and implementation of family support plans that outline therapeutic intervention techniques for the management of behaviors or the development and reinforcement of competent social interactions. They are also responsible for the supervision of Therapeutic Child Support Staff. Therapeutic Child Support Professionals are supervised, at a minimum, two times per month (at least once individually) by an Independent Clinical Practitioner or *a* Practitioner with clinical supervision.

(2) Therapeutic Child Support Staff under supervision of a Therapeutic Child Support professional, Practitioner with Clinical Supervision, or Independent Clinical Practitioner. They are supervised at a minimum; two times per month (at least once individually).

Therapeutic Child Support staff shall:

(aa) be a high school graduate or have obtained a GED: and

(bb) have one year of supervised experience working in a human service program or one year of college; and

(cc) In addition to the above, support staff who provide one-on-one services to children, away from the direct supervision of an Independent Clinical Practitioner, Practitioner with Clinical Supervision, or one of Therapeutic Child Support Professionals or Staff listed above, shall have had at least ***six*** (6) months experience working with children in a supervised program setting.

(3) Parent to Parent Support Staff

Parent to Parent Support Staff shall earn ten (10) hours of initial and continuing training per year to obtain and maintain certification. Documentation of certification shall be maintained through the Office of Family Leadership.

Therapeutic support services may also be provided by parents of a child with an emotional, behavioral, or mental disability who has received at least one state funded service for that child's disability. Parent to Parent Support staff shall work under the supervision of an Independent Clinical Practitioner, Practitioner with Clinical Supervision, or a Therapeutic Child Support Professional. They are supervised at a minimum, two times per month (at least once individually).

(c) Case Managers

(1) DCBS case manager (for children in the custody of or under the supervision of DCBS

(2) Impact Service Coordinator (for case management services only)

(3) Other case managers who meet the following:

(aa) A Bachelor of Arts or Science Degree in any of the behavioral sciences from an accredited

institutiCn. Behavioral sciences include psychology, sociology, social work, human services, and special education; and

(bb) One (1) year of experience in performing case management services or working directly with children. ***A*** Masters Degree in a behavioral science can substitute for the one (1) year experience; **and**

(cc) Completed a case management certification or training course, provided by the DMHMRS within six months of his employment date; and

(dd) Shall work under the supervision of an Independent Clinical Practitioner, Practitioner with Clinical Supervision, Therapeutic Child Support Professional or by a case manager with *two* (2) years of case management experience.

(d) Therapeutic Foster Parents

Therapeutic Foster Parents, under clinical supervision, provide in-home support services to children who receive Therapeutic Foster Care Services. Each foster parent shall meet the following requirements:

(aa) Be approved and supervised by a child-placing agency licensed in accordance with KRS 199.640 and 905 KAR 1:310.

(bb) Complete Thirty (30) hours of pre-service training using an approved curriculum; and

(cc) Twenty-fqur (24) hours of continuing training the first year and every year thereafter related to the care of children with an emotional disability. No more than six hours of annual training shall be provided through individual consultation.

C Qualifications *of* Children

Impact Pius services shall be available to Kentucky Medicaid-eligible children under *aye* 21 who have complex behavioral health care needs and:

(1) meet the conditions and circumstances of the Department for Community Based Services to be defined as a child and in the custody of the state, under the supervision of *the* state or at risk of being in the custody of the state and is in an institution or at risk of institutionalization.

OR

(2) Is in an institution or is at risk of institution-alization.

D. impact Plus Process

(1) Medicaid-eligible chiidren who meet the criteria in C.1. above, shall be reviewed at the local level by the DCBS District Manager or designee, who shall determine the appropriateness of community-based Impact Plus Services, and if appropriate shalt authorize case management services.

If DCBS determines that a child is not appropriate for Impact Plus Services, then the District Manager shall forward this information to DMS's Peer Review Organization and in-patient providers who might serve the child.

The DCBS District Manager shall have the authority *to* authorize emergency services.

(2) Medicaid-eligible children who meet the criteria *in C.* 2 above shall be reviewed *at the local* level by the Regional Interagency Council (RIAC) or designee, who shall determine the appropriateness of community-based Impact Plus Services, and if appropriate shall authorize case management services.

If the RIAC determines that a child *is* not appropriate for Impact Plus Services, then the RIAC shall forward this information to DMS's .Peer Review Organization and in-patient providers who might serve the child.

The RIAC chair or designee shall have the authority to authorize emergency services.

Client Rights

(1) Clients shall have freedom of choice of case management providers for Impact Plus services;

(2) Clients shall have freedom of choice of all service providers of any other Mediczid-covered services.

E. Medical Records

Medical records shall substantiate services billed. Records shall include a service plan, type of service provided, written description of service, date of service, number of units or starting and ending times, place of *service,* and the staff person or persons providing the service. All records shall be personally signed and datkd by the person providing the *service.* Service provisions which require supervision shall also require a co-signer.

Records shall be maintained for a minimum of five *(5)* years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments shall be maintained in an organized file and furnished upon request and made available for inspection and copying by Department personnel or other agencies referenced in 907 KAR 3:030.

IV. COVERED SERVICES

Impact Plus covered services may include.

A. Individual Services

Individual service is defined as any service provided to a child on an individual basis. Services shall be provided by staff who meet the credentials as referenced in Section ill, Conditions of Participation, of this manual.

Examples of these services include, bur are not limited to:

1) Behavioral health evaluations and consultations. These services shall be limited to Independent Clinical Practitioners.

2) Psychotherapy (individual and group) including the development of an individual plan of treatment, the provision of clinical services in accordance with the plan of treatment, emergency services, and expressive therapy. These services shall be limited to Independent Clinical Practitioners and Practitioners with Clinical Supervision.

3) Prescriptions' of medications and on-going management of medications! This service shall be limited to physicians and ARNPs.

4) Therapeutic intervention techniques for the management of behaviors or the development and reinforcement of competent social interactions.

5) Therapeutic Child Support Services

These services shall be provided by therapeutic child support staff or parent to parent support staff who are supervised according to Section III, Conditions of Participation of this manual. These interventions and services shall be identified in the child's service plan and may include the following:

fa) Therapeutic family support groups. They are provided singly, or in combination with other family members or parents *to* assist the child and family in understanding, identifying and coping with stresses associated with the child's disability. These services may include, but are not limited to, supportive skills training and the forming and leading of support groups.

(b) Therapeutic independent living transition supports. These services are provided for those youths who, because of age, are about to transition from many of the services and support provided to younger children with a similar disability. These services may include, but are not limited to, interventions and therapeutic supports that will assist the youth in developing the necessary skills in preparation for an independent living setting. Services can include assessment of a youth's aptitude for vocational training and skill training. Therapeutic intervention techniques and supports to the youth, parent and other family members, are offered for aiding and empowering the youth during the transition. Periodic monitoring of the youth's progress is another support that may exist during the transition.

(c) Behavior management skills training. This service involves supportive intervention techniques and assistance for the child and his or her family regarding behavior management techniques and interventions. This service may include, but is not limited to, assisting the parents or guardians in implementing a behavior management plan for the child. This service may also include individual and group instruction for the child and family members to assist in recognizing and coping with the child's maladaptive behavioral patterns. It may also provide an opportunity for the child to practice adaptive and appropriate behaviors with a focus on needed interventions by the family.

(d) In-home support. This service involves the provision of consultation and education services in the child's home setting to the child, parents and family members. This service is intended to decrease or minimize the child's risk of imminent hospitalization by stabilizing the home environment. This service may include;

1) assessment of the child's current living situation,

2) assisting the parents and family members in restructuring the child's home living situation, and

3) therapeutic techniques training for parents and other family members,

(e) Mentoring with the child. This service is provided for the purpose of assisting a child with building social skills and modeling appropriate social behaviors for the child. Such supportive interventions may include *the* enhancement of appropriate social interactions and daily living skills and intervention techniques building upon the chiid's strengths'.

(9 Parent to Parent support, education and mentoring. This service involves the provision of training and educating a child's parent or guardian of their importance in the development of the chiid's service plan. Services to the parent are provided on behalf of the child. This service may include;

1) information about Impact Plus services, including case management and other needed services,

2) developing advocacy skills;

3) helping to train and empower parents to address a child's case management needs through participation in the child's service planning meeting(s), and

4) modeling communication and intervention strategies.

This service shall be provided by a parent of a child with an emotional, behavioral, or mental disability who has received at least one state funded service for that child's disability.

Reimbursement for this service shall not be made for a child who is related to or living with the parent to parent staff.

B. Group Services

Group services are those services provided in a group setting. A group shall be defined as two or mare children.

Examples and provider limitations of these services are referenced in (A) above, but in a group setting.

C. Collateral Services

Collateral Services are face-to-face encounters with parents. legal representatives, school personnel or other persons in the position of custodial control or supervision of the client for the purpose of providing consultation on behalf of the child in accordance with the child's treatment plat?.

Examples of these services are:

1) Therapeutic assistance to parent(s) or other caregivers through the teaching of mental health intervention techniques; including the recording of behaviors and responses for use in determining the treatment plan and any changes to an existing treatment plan.

2) Consultation services to parent(s); caregivers, or other persons of the child's team to assure an appropriate understanding of the treatment goals and the strategies for successful implementation and follow-up.

Collateral services may be provided either individually or in a group setting and shall only be provided by Independent Clinical Practitioners and Practitioners with Clinical Supervision as referenced in Section III, Conditions of Participation, of this manual.

SECTION IV- COVERED SERVICES

D. Targeted *Case* Management Services

Case management services are defined as services to assist children in gaining needed medical, educational, social and other support services. Case management services may include:

1) assessment of family strengths and needs,

2) assistance in developing, coordinating, and accessing services in the individual service plan and family support plan,

3) coordination of interagency team meetings to develop a family support plan,

4) facilitation of the implementation of the child and family service plans,

5) monitoring progress and performing advocacy to assure appropriate, timely, and productive treatment and support services, and

6) participation in the development of other human service plans for the child.

Limitations of Targeted *Case* Management Services

Case management services shall not include:

1. The actual provisions of treatments;

2. Outreach activities to potential clients;

3. Administrative activities associated with Medicaid eligibility determinations, application processing, etc.;

4. Institutional Discharge Planning - This service is required as a condition of payment for institutional (hospital, nursing facilities) services and therefore, shall not be covered under the Targeted Case Management Program. The case management provider may bill, however, for case management services performed either in the month prior to or month of discharge from the facility to prepare for the individual's return to the community;

5. Transportation services solely for the purpose of transporting the individual; and

6. Payment for Case Management services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Documentation of Case Management Services

1. This unit of service requires, at least, four *(4)* contacts per month: one (1) contact shall be face-to-face with the child and one (1) face-to-face with the parentlguardian. The record shall designate in some manner the four (4) required service contacts each month for billing purposes.

2. The requirement of four (4) service contacts per month is still required for children in out-of-region or out-of-state placements. A telephone contact with the child may substitute for the face-to-face contact. However, the face-to-face contact is strongly encouraged. The face-to-face contact with the parentlguardian shall not be substituted.

E. Therapeutic After School and Summer Programs

These programs are defined as structured day programs focusing on the use of appropriate behaviors and social skills in group activities with other children. Unlike day treatment, therapeutic after school and summer programs do not include an accredited educational curriculum provided in collaboration with a certified educational program.

All services shall be provided in accordance with an individual treatment plan and may include:

- group activities that promote developmentally appropriate social skills with the child and with the family;
- daily clinical monitoring and intervention;
- individual, group, or family therapy:
- coordination with teachers, parents, or caregivers;
- scheduled activities that promote family involvement and empower the family to meet the child's needs;
- recreation therapy: and
- an individualized behavioral management plan developed by an independent Clinical Practitioner or practitioner under clinical supervision

Programs shall have continuing on-site supervision by an Independent Clinical Practitioner. Staff to child ratio shall be at a minimum, two (2) staff for every eight (8) children fur Therapeutic Activities and, at a minimum, one (1) Independent Clinical Practitioner or Practitioner under Clinical Supervision and one (1) other staff person for each clinical group activity.

Typically these services will be provided by staff employed by one of the following:

1) a community mental health center
2) a child caring or placing agency
3) a DATE center
4) a NATE center
5) a *hospital*

6) a community school building
7) a clinic
8) an outpatient office

F. Day Treatment Services

Day treatment is defined as a community-based program of diagnostic, treatment, and rehabilitative services provided in collaboration with the special education services of the Local Education Authority (LEA) on school days. This service may also be provided during the summer.

Typically these services will be provided by staff employed by one of the following:

1) a community mental health center
2) a child caring or placing agency
3) a DATE center
4) a NATE center
5) a hospital

All services shall be provided in accordance with an individual treatment plan and shall include, but not be limited to:

- individual, group or family counseling;
- behavior management or social skills training;
- treatment-based schooling provided by the LEA, as required by law (not covered under Medicaid);
- independent living skills for youth age 14 and above;
- scheduled activities to promote family involvement and to empower the family to meet the child's needs; and
- services designed to explore and link with community resources before discharge and to assist the child and family with transition to community services after discharge.

A linkage agreement between the agency providing clinical service and the LEA shall identify the responsibility of each party for the provision of the following:

- continuing on-site supervision by a Independent Clinical Practitioner;
- appropriately licensed teachers;
- educational supports (classroom aides, textbooks);
- educational facilities;
- physical education and recreational therapies:
- transportation; and
- transition planning.

The program shall have unified policies and procedures accepted by both *education* and mental health staff which address program philosophy, admission and exit criteria, admission process, staff training and integrated case planning. Staff, to child ratio shall be, at a minimum, two (2) staff with eight (8) children for therapeutic activities and, at a minimum, one (1) Independent Clinical Practitioner or Practitioner Under Clinical Supervision and one (1) other stair' person for each clinical group activity.

The individual treatment plan shall be coordinated with the Individual Educational Plan. Homebound instruction will not be permitted.

G. Partial Hospitalization Services

Partial hospitalization *is* defined as an organized intensive treatment program offering less than 24-hour daily care, available five to seven days per week as an alternative *to* inpatient treatment which provides a stable therapeutic environment for the comprehensive assessment, diagnosis, and treatment of complex behavioral health needs.

Appropriate for short-term treatment when a highly structured environment **but** *not* 24-hour intensive treatment *is* needed. All services shall be provided in accordance with an individual treatment plan and shall include but not be limited *to:*

- daily psychiatric oversight and management which includes daily communication with staff delivering direct

services and face-to-face contact with the child one or more times *per* week
- continuous nursing coverage;
- multi-disciplinary treatment team;
- rehabilitative therapy;
- individual, group or family counseling;
- medication evaluation, education, and management;
- behavior management or social skills training;
- treatment-based schooling provided by Local Education Authority (LEA), as required *by* taw (not covered under Medicaid);
- scheduled activities which promote family involvement; and
- the development with the child and family of a crisis plan to assist with stabilization during non-program hours.

A linkage agreement between the agency providing clinical service and the LEA shall identify the responsibility for the provision of the following:

- continuing on-site supervision by a Independent Clinical Practitioner;
- appropriately *licensed* teachers;
- educational supports (classroom aides, textbooks);
- educational facilities financed by the LEA as required by law (not covered under Medicaid);
- physical education and recreational therapies;
- transportation; **and**
- transition planning.

The program shall have unified policies and procedures accepted by both education and mental health staff which address program philosophy, admission and exit criteria, admission process, staff training and integrated *case* planning.

The individual treatment plan shall be coordinated with the Individualized Educational Plan.

Services shall be provided by staff (professional and support) employed by or under contract with an agency licensed as either a community mental health center or hospital. Staff to child ratio shall be, at a minimum, two (2) staff with eight (8) children for therapeutic activities and, at a minimum, one (1) Independent Clinical Practitioner or Practitioner under Clinical Supervision and one (1) other staff person for each clinical group activity.

H. Intensive Out-patient Services

Intensive out-patient services consist of a structured comprehensive program of individual and group activities provided at feast three (3) times weekly for a minimum of two (2) hours' per day.

These services shall be provided by an Independent Clinical Practitioner, Practitioner with Clinical Supervision, qualified substance abuse professional, community mental health center, a hospital, or a NATE or DATE center.

NOTE: The following list (I. through L.) reflects residential treatment services covered under Impact Plus. Note these services include overnight stays and the cost of room and board *is* not covered.

I. Therapeutic Foster Care Services

Therapeutic foster care is provided through a Therapeutic Foster Family Treatment plan that is part of the individual service plan and coordinated with service plans by other agencies for the child that includes:

- Weekly in-home clinical supervision and support by an Independent Clinical Practitioner or Practitioner with Clinical Supervision of the Therapeutic Foster Parent?
- Behavior management plan developed by the clinical services provider and implemented and documented daily by the Therapeutic Foster Parent:
- Crisis stabilization plan;

- Identified supports for the Therapeutic Foster Parents (e.g.; foster parent support groups, etc.); and
- Plan for involvement and visitation of the child with the birth family/guardians/or other natural supports unless prohibited by the court.

These services shall be provided by a Therapeutic Foster Parent under the supervision of an Independent Clinical Practitioner or Practitioner with Clinical Supervision employed by or under contract with a licensed child placing agency and in a home setting where the therapeutic foster parent resides.

J. Therapeutic Group Residential Care Services

Therapeutic group residential care includes specialized programs focused on particular population: e.g., children with a history of sexual victimization and/or perpetrator; or children with dual diagnosis.

Services are provided through a residential treatment plan that is part of the individual service plan and coordinated with service plans by other agencies for the child that includes:

- weekly *on-site* clinical supervision and continuing consultation and support of the residential staff by an Independent Clinical Practitioner:
- behavior management plan developed by the Independent Clinical Practitioner and implemented and documented daily by the residential staff;
- crisis stabilization plan; and
- plan for involvement and visitation of the child with birth family or guardians or other natural supports unless prohibited by the court.

These services shall be provided by professional and support staff employed by or under contract with a licensed child caring agency or DSS, or NATE or DATE centers who are licensed to provide residential services.

K. Residential Crisis Stabilization Services

Residential *crisis* stabilization is defined as short-term mental health treatment, usually less than seven (7) days, available 24 hours per day, seven days per week, in a structured, community-based therapeutic environment. It is most often used to prevent the placement of a child in inpatient, psychiatric residential, or residential treatment care.

Appropriate when:

- the child must immediately leave his home environment to resolve the crisis;
- the crisis is short-term;
- intensive medical treatment is not required; and
- the child's primary need is for mental health treatment rather than shelter.

Servi

times.

NOTE: A child shall not be moved from a hospital based crisis service to an inpatient bed without having that admission approved by the DMS's Peer Review Organization (PRO).

Services shall be provided by an Independent Clinical Practitioner and staff employed by or under contract to a licensed child caring agency, hospital, or a DATE or NATE center licensed for residential treatment.

L. Wilderness Camp

Wilderness camp is defined as a structured program of individual and group activities that include overnight experiences in an outdoor environment. Rehabilitative interventions are designed to build social competencies, to increase self esteem, and to learn and practice skills that provide for greater control of personal behaviors.

An individual Clinical Practitioner shall be on-site at all times.

Wilderness camp services shall be provided by an Independent Clinical Practitioner and staff employed by or under contract with a licensed child caring facility and in accordance with the individual service plan.

V. REIMBURSEMENT

Reimbursement shall be as follows:

1) Payments shall be based on cost.

2) When the Title V agency, DCBS or DMHMRS provides the service directly, it shall maintain adequate service and cost records to show that payment does not exceed cost.

3)

of service, amount paid for the service, etc.

4) The payment rates to be paid to subcontractors shall be negotiated between the Title V agency, or DCBS or DMHMRS, *and* the sub-contractor. The negotiated rate shall not be effective until approved by Medicaid. To facilitate deveiopment of approvable negotiable rates the Medicaid representative shall, when deemed necessary or appropriate by the Medicaid Program, participate in the negotiation process.

5) The Medicaid approval of the negotiated rate shall not be

he
standards
service in
regulation may
subject to recoupment
been approved by Medicaid.

6) if a service is provided by a subcontractor and a negotiated rate for the service has not been established, the service shall be considered to be a non-covered service if a rate is not negotiated within thirty (30) days. Approval for negotiated rates shall be requested in advance of provision of the service except in extenuating situations as reviewed and approved by the **DMS.**

7) Depending on the services provided, a billable unit of service shall be in increments of:

a) Fifteen (15) minutes,

b) one hour,

c) one twenty-four (24) hour day, or

d) one calendar month.

8) The cost of room and board shall not be reimbursed under Impact Plus.

MAP -3 43 (REV. 7/97)

COMMONWEALTH OF KENTUCKY
MEDICAID SERVICES
CARE PARTNERSHIP
BEHAVIORAL HEALTHCARE
ORGANIZATION

PROVIDER AGREEMENT

DATE OF AGREEMENT _____ Provider # _____

1. The Provider agrees to abide by the following terms and conditions relating to the Kentucky Medicaid Program:

_____
Provider

whose principal place of business is located at the following address:

_____
Street

_____
City State zip Code

The above listed provider holds a license/certificate, _____ (Number) as a _____ *(Type of Provider)* if required. under the laws of the Commonwealth of Kentucky to provide _____ *(Type of Service)* for which this agreement applies.

3. Scope of Agreement

This provider agreement sets forth the rights. responsibilities. terms and conditions governing the provider's participation in the Kentucky Medicaid program Kentucky Heaith Care Partnership 'Managed Behaviorai Healthcare Organization (MBHO) and, for those providers participsting in the Partnership/MBHO. suppiemencs those terms and conditions imposed by the Partnership/MBHO governing board.

3. Medical Services to be Provided

The provider agrees to provide covered services to Medicaid recipients in accordance with all applicable federal and state laws, regulations, policies, and procedures relating to the provision of medical services according to Title XIX. the approved Waivers for Kentucky and. for those providers participating in the Partnership/MBHO. all applicable provisions of the pertinent contract for managed care 2nd policies and procedures duly adopted by the governing board of the Partnership/MBHO applicable to provider and recipients of Title XIX services.

4. Assurances

The Provider:

(1) Agrees to maintain such records. including electronic storage media. as are necessary to document the extent of services furnished to Title XIX recipients for a minimum of 5 years or as required by state or federal laws, and for such additional time as may be necessary in the event of an audit exception.quality of care issue. or other dispute and to furnish the state or federal agencies with any information requested regarding payments claimed for furnishing services.

(2) Agrees, to permit representatives of the state and federal government, and for those providers ,participating in Partnership/MBHO. staff of the Kentucky Health Care Partnership/MBHO, to have the unrestricted right to examine Inspect, copy and audit all records pertaining to the provision of services furnished to Title XIX recipients. Such examinations. inspections. copying and audits may be made without prior notice to the Provider. This right shall include the ability to interview facility staff during the course of any inspection. review, investigation or audit.

(3) Agrees to comply with the Civil Rights requirements set forth in 45 CFR Parts 80, 84. and 90 and the Americans with Disabilities Act (ADA). 42 USC 12101. Payments shall not be made to providers who discriminate on the basis of race. color. national origin. sex. disability. religion. age or marital status in the provision of services.

(4) Agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for Title XIX recipients in order to ensure quality of care and avoid the provision of duplicate or unnecessary medical services.

(5) Assures awareness of the provisions of 42 U.S.C. § 1320a-7b reproduced on the reverse side of this agreement and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid Program Fraud and Abuse, and applicable Kentucky Administrative Regulations as specified in Title 907 relating to the Kentucky Health Care Partnerships and Managed Behavioral HealthCare Organizations and Provider Agreements.

(6) Agrees to inform the Cabinet for Health Services, Department for Medicaid Services. or the appropriate Partnership/MBHO,

A. within 30 days of any change in the following:
   1. name;
   2. ownership;
   3. address; and

B. within five (5) days of information concerning the following:

1. change in licensure/certification
2. regulation status:
3. disciplinary action by the appropriate professional association:
4. Criminal charges

(7) Agrees to the following:

a) to assume responsibility for appropriate. accurate. and timely submission of claims and encounter data whether submitted directly by the provider or by an agent;

b) that the provider's signature on this agreement constitutes compliance with the following: the transmitted information is true. accurate. and complete and any subsequent correction which alter the information contained therein will be transmitted promptly:

) ■ payment and satisfaction of claims will be from federal and state funds end that any false claims statements, or documents or concealment or falsification of a material fact. may be prosecuted under applicable federal and state law.

(8) Agrees to participate in the quality assurance programs of the' partnership/MBHO and the Department for Medicaid Services and understands that the data will be used for analysis of medical services provided to assure quality of care according to professional standards.

(9) Agrees if the provider is the purchaser of a pre-existing business 'enrolled in the Partnership/MBHO or Medicaid program. the purchasing provider agrees to assume any outstanding liabilities of the previous owners payable to the Partnership/MBHO or Medicaid program.

(10) Agrees to notify the Department for Medicaid Services and the Partnership MBHO in writing of having filed for protection from creditors under the Bankruptcy Code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court. and the identity of the court in which the petition was filed.

(11) Agrees to return any overpayment made by the Department for Medicaid Services. or Partnership/MBHO resulting from agency error in calculation of amount or review of submitted claims.

(12) Agrees to refund to the Kentucky State Treasurer. the processing fee incurred by the fiscal agent for the Department for Medicaid Services. in the event claim submission has an error rate of 25% or greater.

(13) Agrees if the named Provider in this agreement is a nursing facility or ICF/MR/DD this agreement shall begin on _____, 199___, with conditional termination on _____, 199___, and shall automatically terminate on _____, 199___, unless the facility is re-certified in accordance with applicable regulations and policies.

5. Payment

In consideration for the provision of approved Title XIX services rendered to Medicaid recipients and subject to the availability of federal and state funds:

(1) The Cabinet for Health Services. Department for Medicaid Services agrees to reimburse the provider according to current applicable federal and state laws. rules and regulations and policies of the Cabinet for Health Services for providers participating as direct Medicaid-payment providers. Payment shall be made only

upon receipt of appropriate billings and reports as prescribed by the Cabinet for Health Services, Department for Medicaid Services.

(2) The Partnership/MBHO agrees to reimburse the provider according to the provisions of the Partnership/MBHO agreement with the provider. Payments shall be made only upon receipt of appropriate encounter data, claims and reports as prescribed by the Partnership/MBHO governing board.

6. Provider Certification

(1) If the provider is required to participate or hold certification under Title XVIII of the Social Security Act to provide Title XIX services, the provider assures such participation or certification is current and active.

(2) If the Provider is a specialty hospital providing psychiatric services to persons age 21 and under the Provider shall be approved by the Joint Commission on Accreditation of Health Care organizations In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on the Accreditation of Health Care Organizations.

7. Lobbying Certification

The provider certifies that to the best of one's knowledge and belief, that during the preceding contract period, if any, and during the term of this agreement:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influence or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee or Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL 'Disclosure Form to Report Lobbying' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352 Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

8. Termination

(1) The Department for Medicaid Services, Partnership/MBHO or provider shall have the right to terminate this agreement for any reason upon 30 days written notice served upon the other party by registered mail with return receipt requested. The

Partnership/MBHO or Department for Medicaid Services may terminate this agreement "'immediately for cause. or in accordance with state or federal laws. upon written notice served upon the Provider by registered mail with return receipt requested.

(2) If the provider is terminated by Medicare or Medicaid. the Partnership/MBHO shall also terminate the provider from participation.

(3) If there is a change of ownership of a nursing facility or ICF/MR/DD facility, the Cabinet for Health Services agrees to automatically assign this agreement to the new owner according to 42 CFR $442.14.

9. Incorporation of Attachments
Attachments MAP-343B "Disclosure of Ownership and Control Interest"

_____,
_____ and
_____ are
attached hereto and incorporated by reference.

PROVIDER:

_____
Name

_____
Title

_____
Date

HEALTH CARE PARTNERSHIP
OR
MANAGED BEHAVIORAL HEALTH
ORGANIZATION

by: AUTHORIZED OFFICIAL

_____
Name

_____
Title

_____
Date

DEPARTMENT FOR MEDICAID SERVICES

_____
Name

_____
Title

_____
Date

MAP-343B
Rev. [illegible]

Appendix II

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY HEALTH CARE PARTNERSHIP
MANAGED BEHAVIORAL HEALTH CARE ORGANIZATION

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

COMPLETION OF THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR § 455.104 AND KRS CHAPTER 205, AS AMENDED). FAILURE TO FULLY RESPOND TO THE QUESTIONS SET FORTH IN THIS FORM MAY RESULT IN DELAY IN APPROVAL OF YOUR APPLICATION FOR PROVIDER PARTICIPATION OR DENIAL OF YOUR APPLICATION FOR PARTICIPATION.

All areas must be filled out in entirety. If you think that certain questions do not apply you may state not applicable. Please print or type information.

Provider/Entity Agent for Service of Process

1. (A) Has there been a change of ownership, change of tax ID number, or change in Kentucky Provider Number for a previously enrolled Kentucky Medicaid provider?
_____ Yes _____ No

If yes, give previous Kentucky Medicaid provider #: _____ and Effective Date _____

If yes, describe the relationship between (1) the current provider disclosing information through this form and the previous Medicaid provider; and (2) the similarities, if any, between the corporate board of the current provider disclosing information and the previous Medicaid provider (corporate board members, any ownership or control interest, etc.) (3) circumstances of disenrollment. (You may attach additional sheet. if necessary.)

(B) Do you anticipate any change of ownership or control within the year? ___Yes___No
If yes, when? _____

(C) Do you anticipate filing for bankruptcy within the year? _____ Yes _____ No
If yes. when? _____

(D) Is this provider/facility operated by a management company, or leased in whole or part by another organization? _____ Yes _____ NO

the last year? _____ Yes _____ No
If yes, when? _____ List name and address _____

(F) Is this facility chain affiliated? _____ Yes _____ No
(If yes, list name, address of Corporation, and EIN#)

SAME	ADDRESS	EIN#

2. hav
CF

Include social security number and/or IRS tax identification as appropriate.

NAME	ADDRESS,	ss #/EIN#

3. List the name, address, and SS #/EIN # of each person with an ownership or control interest, a defined by 42 CFR 455.101 and 102, in any subcontractor in which the disclosing entity ha direct or indirect ownership of 5 percent or more. Include social security number and/or IRS ta identification number of the subcontractor as appropriate.

NAME	ADDRESS	SS #/EIN#

4. Ace any of the individuab above related to one another as spouse, parent, child, or siblin (including step and adoptive relationship)? _____ Yes _____ No

If yes, complete the following information:

Names	SS #/EIN #	Relationship

5. List the names of any other disclosing entity in which person(s) listed have ownership of oth Medicare/Medicaid facilities as defined by 42 CFR 455.101 and 102.

NAME	ADDRESS	PROVIDER NUMBERS

6. List the names and addresses of all other Kentucky Medicaid providers with which your heal service and/or facility engages in a significant business transaction and/or a series of transactio that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operati espense.

NAME	ADDRESS

8. List the name. address. and social security number of any immediate family member who is authorized under Kentucky law to prescribe drugs. medicine. medical devices. or medica equipment in accordance with KRS 205.8477

_____

_____

S. List the name of any individuals or organizations having direct or indirect ownership or contro interest of 5% or more in the institution. organizations. or agency that have been convicted of a criminal offense related to the involvement of such persons. or organizations in any program established under Title XVIII (Medicare). Title XIX (Medicaid), or Title XX (Social Service Block Grants) of the Social Security Act or any criminal offense in this state or any other state.

_____

_____

9. List the name of any agent and/or managing employee of the disclosing entity who has bee convicted of a criminal offense related to the involvement in any program established under Titl XVIII, XIX, or XX of the Social Security Act or any criminal offense in hth state or any othe state.

_____

_____

CAUSES TO BE MADE,
STATEMENT SHALL B
L OR STATE LAW
THE INFORMATIO
TO F

OR TERMINATION OF THE CURRENT AGREEMENT WITH THS STATE AGENC? AS REQUIRED BY 42 CFR 455.104 AKD KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given

Program and/or for prosecution for Medicaid fraud. I hereby authorize the Cabinet for Heal Services, the Kentucky Health Care Partnership or Managed Be navioral Health Ca Organization to make all necessary verification concerning me and/or my medic

participation in the Kentucky Medicaid Program

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Appendix II

(a) Making or causing to be made false statements or representations
Whoever-
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a fe
health care program (as defined in subsection (f) of this section),
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit
payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to a
benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an int
fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,
(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such be
payment or any part thereof to a use other than for the use and benefit of such other person,
(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the indivi
furnished the service was not licensed as a physician, or
(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan
subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title,
shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items o
for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more th
years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conv
thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assis
a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwit
any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate, but th
imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other perso
assistance under the plan, regardless of the relationship between that individual and such other person.
(b) Illegal remunerations
(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whol
under a federal health care program, OC
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payn
made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprise
more than five years, or both.
(2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or i
person to induce such person-
(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part un
health care program, or
(B) to purchase, lure, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in wh
part under a federal health care program,shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more th
or both.
(3) Paragraphs (1) and (2) shall not apply to-
(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly r
appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;
(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered
services;
(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing ser
reimbursed under a Federal health care program if-
(i) the person has a written contract with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or
percentage of the value of the purchases made by each such individual or entity under the contract, and
(ii) in the case of an entity that is a provider of services (as defined in section 1393x(u) of this title), the person discloses (in such form and manner as the Secretary r
the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;
(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifi
subsidized services under a provision of the Pubic Health Service Act [42 U.S.C.A. § 201 et seq.];
(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protect
1987; and
(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement be
organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk
arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the indivic
is obligated to provide.
(c) False statements or representations with ruprt to condition or operation of institutions
Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact wi
the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon r
as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other e
(including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health
(as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony
conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(d) Illegal patient admittance and retention practices
Whoever knowingly and willfully-
(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess
established by the State, or
(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter
money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the pa
(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) u
plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(E) Violation of assignment terms
Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) o
knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fine
$2,000 or imprisoned for not more than six months, or both.
(f) "Federal health care program" defined
For purposes of this section, the term "federal health care program" means-
(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the Unit
Government (other than the health insurance program under chapter 89 of Title 5); or
(2) any State health care program, as defined in section 1320a-7(h) of this title.

MAP-344
Rev. (7/97)

KENTUCKY MEDICAID PROGRAM

PROVIDER INFORMATION

1. _____
(Provider/Entity) (Provider Number)

2. _____
DBA (Type of Provider)

3. _____
(Physical Location Address: Street, Route)

4. _____
(City) (County) (State) (Zip Code)

5. _____
(Office Phone # of Provider) (Billing Office Phone # and Contact Person)

6. _____
(Correspondence Address, if different from physical location)

_____
(City) (County) (State) (Zip Code)

7. _____
(Pay to Address, if different from physical location)

_____
(City) (County) (State) (Zip Code)

8. _____
(Federal Empioyee I.D.#)

9. _____
(Social Security #)

10. _____
(License # and State)

11. _____
(Medicare Numbers- If pending must notify us in writing when received from Medicare)

12. _____
(UPIN #)

13. _____
(NPI #)

14. _____
(Licensing/Certification Board)

15. _____
(Original License/Certification Date)

16. _____
(CLIA #)

17. _____
(Type of CLIA Certificate) (Must be attached

MAP-344
Rev. (7/97)

18. Physician/Professional Specialty Certification Board: _____

_____

1st _____ Date _____

2nd _____ Date _____

Attach Copy of Board Cenification.

19. Federal DEA # and Date Assigned: _____

20. Practice Organization/Structure:

_____ (A) Individual
_____ (B) Sole Proprietor
_____ (C) Partnership*
_____ (D) Estate/Trust
_____ (E) Corporation
_____ (F) Public/Service Corporation
_____ (G) Government/Non-Profit
_____ Other _____ Specify

*Refers to tax structure not Managed Care Partnerships

21. If Corporation, list name, address and SS # of Officers and Board Members:

NAME	ADDRESS	SS#

22. If partnership*, list name, address, and SS #/EIN # of partners:

NAME	ADDRESS	SS #/EIN#

*Refers to tax structure not Managed Care Partnerships

23. If sole proprietor, give name, address, and phone number of owner:

_____

_____

(A) List name of agent for service of process:

_____

MAP-X
Rev. (7/97)

24. Control of Medical Facility, Provider. or Service:

_____Federal _____State _____County _____City
_____Charitable or Religious _____Proprietary (Privately-Owned)
_____Other Specie: _____

25. If facility, provider, or service is government owned, list names and address o board members:

President/Chairman _____

Member: _____

Member: _____

TO BE COMPLETED BY FACILITY ONLY
****

26. Distribution of beds in facility: Acute (including Swing) _____ ICU _____
CCU _____ TCU _____ Bum ICU _____ Surgical ICU _____
Psych _____ Rehab _____ Nursery _____ Neonatal _____
Chemical Dep. _____ Nursing (SNF, LTC, NF, etc.) _____
Intermediate Care _____ Nursery Bassinets _____ Other _____
(Specif)

27. Have you increased your bed capacity by 10% or by 10 beds, whichever is gr ater, within the last 2 years? _____ Yes _____ No
If yes, give year of change. _____ Current Beds _____ Prior Beds

28. Fiscal Year End: _____

29. Administrator: _____

30. Assistant Administrator: _____ Phone # _____

31. Controller: _____ Phone # _____

32. Accountant or CPA: _____ Phone # _____

33. Management Firm: _____

34. Lessor: _____

Provider Authorized Signature: I certify, under **penalty** of law. that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I hereby authorize the Cabinet for Health Services to make all necessary verification concerning me **and/or** my **medical** practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____ Date: _____

Printed Name: _____

Title: _____

FOR INDIVIDUAL PROVIDERS ONLY

COMPLETION OF THIS SECTION IS VOLUNTARY

Information is used ONLY for **statistical** purposes.

RACE	SEX	DATE OF BIRTH
_____	_____	_____

UNISYS MEDICAID'S FISCAL AGENT INFORMATION

Unisys Corporation
Addresses:

Accident & Work Related
Post office Box 2107
Frankfort, KY 40602

Adjustments & Claim Credits
Post Office Box 2108
Frankfort, KY 40602
Claims Submission
Post Office Box 2101
Frankfort, KY 40602

Electronic Claims Submisson
Post Office Box 2016
Frankfort, KY 40602

Provider Relations (Inquiries)
Post Office Box 2100

Frankfort, KY 40602

Third Party Liability
Post Office Box 2107
Frankfort, KY 40602

Unisys Telephone Numbers
In State-Kentucky:
Electronic Claims 800/205-4696
Inquiries: 800/807-1232
Unisys Automated Voice Response
System: 800/807-1301 Available 24 Hours

REFERENCE LIST

Department for Medicaid Services
Addresses:
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621
Department for Medicaid Services
In State & Out-of-State

Eligibility (Recipient)	502/564-6885
Fraud Hotline	800/372-2970
Policy	502/564-6890
Enrollment (Provider)	502/564-3476
Third Party Liability	502/564-6205

Where to Order
Diagnostic Code Books
International Classification of Diseases
American Medical Association
P.O. Box 7046; Attn: Order Dept.
Dover, DE 19903-7046

Diagnostic and Statistical Manual
of Mental Disorders (DSM-IV)
American Psychiatric Association
1400 K Street NW
Washington, DC 20005

HCFA-1500 (12/90) Claim Forms
Superintendent of Documents
Post Office Box 371954
202/512-1800

Health Care Review Corporation (PRO)
9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
I-800-292-2392
Fax: (502) 429-5233